Long Term Services and Supports Evaluation of Rebalancing Strategies

Findings from the Qualitative Inquiry

HEALTHCARE AND HUMAN SERVICES POLICY, RESEARCH, AND CONSULTING—WITH REAL-WORLD PERSPECTIVE.

Prepared for: **Rhode Island's Executive Office of Health and Human Services**

Submitted by: **The Lewin Group, Inc.**

October 31, 2016

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RFP MPA 493: EOHHS Long-Term Services and Supports Evaluation of Rebalancing Strategies

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Executive Summary

I. Introduction

The Rhode Island Executive Office of Health and Human Services (EOHHS) Long-Term Services and Supports Evaluation of Rebalancing Strategies (the "Rebalancing Study") aims to identify recommended actions, activities, and policies to reform and rebalance the long-term services and supports (LTSS) system in the state. The *Rebalancing Study* comprised three major activities:

1. An initial Environmental Scan, to understand Rhode Island's current policies and activities around rebalancing the system and other states' mechanisms for change, activities, and impact
2. A Quantitative Study with focused data analysis to identify precipitating factors for individuals in need of or receiving LTSS in Rhode Island (pre-Medicaid and current Medicaid recipients) and to provide data to support recommendations
3. A Qualitative Study to engage stakeholders (e.g., advocates, providers, policymakers) as key contributors to the development of the initial and refined recommended actions, activities, and policies

This report summarizes the findings of the Qualitative Study.

II. Methods

This Qualitative Study builds upon findings from the initial Environmental Scan's preliminary findings about the state of LTSS and rebalancing in Rhode Island in nine policy focus areas. EOHHS selected four reform areas for further inquiry through the Qualitative Study:

A. Eligibility Process

B. Communication, Awareness, and Access to Information

C. Nursing Home Partnerships

D. Delivery System, Provider, and Process Transformation

The Qualitative Study encompassed seven key informant interviews and four focus groups (23 participants). Participants were chosen based on their extensive knowledge of the current state of LTSS in Rhode Island, their senior positions in their organizations, and their ability to think broadly and creatively about rebalancing proposals. Organizations represented in the Qualitative Study included nursing homes, community providers, managed care organizations, elder care attorneys, other advocates, and policymakers. Questions in each topic area sought stakeholders' feedback on current LTSS policy and practices as they relate to rebalancing, barriers to rebalancing, and recommendations to overcome barriers and promote rebalancing, including potential partners, budgetary impact, timing, and metrics to measure success.

III. Summary of Recommendations from Qualitative Study

To fully reflect the richness and diversity of discussion, this report includes the full list of recommendations made by key informants and focus group participants. Stakeholder feedback, combine with other Rebalancing Study activities and project team knowledge and experience, have

informed recommendations contained in the final report, which was provided to EOHHS under separate cover.

A. Eligibility Process

1. Implement presumptive financial eligibility for Medicaid for all Home and Community Based Services (HCBS) waiver programs and provide services while application is pending

A presumptive or expedited eligibility process would enable individuals in need of community-based LTSS to begin accessing benefits while financial eligibility verification is ongoing.

2. To support expedited eligibility, increase assessor capacity to prevent delays in getting a functional assessment

Specifically: (i) expand the types of medical and other professionals who can do assessments; (ii) train hospital discharge staff, managed care organization staff, or other roles as assessors for functional eligibility; (iii) co-locate functional eligibility assessors in hospitals or other medical settings; and (iv) expand the role of the co-located eligibility assessors to assist with care transitions.

3. Create a true single waiver system or standardize requirements for level of care and financial eligibility across all ages and populations. Eliminate variable rules for legacy waivers/programs within the 1115 waiver

Adoption of this recommendation would also eliminate the separate Social Security determination standard for those under 65 who are receiving Social Security Disability Insurance (SSDI).

4. Use one standardized assessment tool and assessment process to determine level of care and functional eligibility for all populations, regardless of age or type of disability

Specifically: (i) eliminate Primary Care Provider sign-off for functional assessment approval; (ii) reduce the number of necessary steps and hand-offs required; (iii) redesign the eligibility application form to be more user-friendly for the consumer and family; and (iv) reduce burdensome documentation such as six months of bank statements.

5. Develop a fully electronic online waiver benefit and financial eligibility platform – from screening to application to determination – and streamline the exchange of functional and financial eligibility determination information among the various units involved

Specifically: (i) develop and maintain a single portal/ online benefits screening and application tool; (ii) allow applicants to complete the entire application process online, including answering supplemental questions and uploading documentation; (iii) set short standard turn-around times for processing each step of the eligibility determination; and (iv) develop and maintain a shared electronic system for LTSS functional and financial eligibility.

6. Increase the community Medicaid personal needs allowance

Increase current monthly personal needs allowance for HCBS, which is currently $923, considering the median amount is $1,962 across all states.

7. Integrate or coordinate Neighborhood Health Plan (NHP) with Rhode Island's Medicaid billing and eligibility system at EOHHS

Coordination of these systems would increase the efficiency of the NHP system and reduce burden on providers.

8. Evaluate the Unified Integrated Eligibility System (UIES) after 3-6 months to understand the implementation of the program from various vantage points and respond accordingly

Consider evaluating UIES through focus groups or interviews with diverse stakeholders, as well as process mapping.

B. Communication, Awareness, and Access to Information

1. Ensure a neutral, impartial resource for LTSS information, independent of the state, for persons regardless of income

Include comprehensive, reliable, up-to-date information that does not "sell" the consumer products or services and information on all LTSS options, both publicly financed and private pay, with expanded support for the pre-Medicaid population (e.g., private case management, reverse mortgages, elder law attorneys, life insurance, dementia care, and adult day programs).

2. Leverage THE POINT as a resource for all seekers of LTSS information by increasing its capacity to provide information and improving access to its services. To do so, would need to increase capacity of and improve access to THE POINT

Increase capacity of THE POINT

a. Create an interactive website for THE POINT dedicated to information for older adults in RI
b. Streamline and standardize training for all No Wrong Door partners on person-centered counseling and HCBS options
c. Allow THE POINT access to and integration with the state's system including eligibility
d. Fund and train additional staff
e. Co-locate staff from the long-term care eligibility offices in THE POINT programs with the highest demand to assist in preparing Medicaid eligibility applications

Improve access to THE POINT

a. Promote a robust series of No Wrong Door entry points that lead to centralized information
b. Provide and monitor customer service performance standards in contracts

c. Promote THE POINT through multi-media awareness campaign (after increasing capacity of THE POINT)
d. Clarify in messaging that THE POINT is not a state agency
e. Standardize the messaging about LTSS statewide. Work with MCOs to ensure their marketing materials are consistent with the standard messaging

3. Conduct a community education campaign to make people aware that community LTSS exist, and standardize the messaging about LTSS statewide

4. Promote Program for All-inclusive Care for the Elderly (PACE) more widely

5. Improve awareness and education regarding HCBS among care transition professionals

6. Clarify each HCBS program's specific rules, and post this information online in one visible, easy-to-find online site (e.g., THE POINT, if revised as recommended)

7. Include more quality measures and "standards of responsiveness" in contracts with providers (e.g. home care, adult day) and make available to consumers.

Develop a quality measures/data book or report card on provider and payor performance; use national measures as comparison metrics.

8. Reduce burden on community partners by establishing longer term partnerships and streamlining the contracting process.

C. Nursing Home Partnerships

1. Reduce statewide bed capacity

a. Continue moratorium on nursing home (NH) beds
b. Target facility closures and/or delicensing of beds through state buyout
c. Maintain beds in the homes with better facilities and higher quality care
d. Utilize flexible licensing in which any bed could be used for any level of care
e. Encourage incentives for conversion of rooms from double to single; increase Medicaid rates
f. Allow providers to buy beds from other providers

2. Expand nursing home business models

a. Consider repurposing whole NH or empty wings in NHs with lower occupancy
b. Utilize entire NH or empty wings for behavioral health (BH) care
c. Encourage expansion of respite beds and services within NHs
d. Create incentives for NHs to include HCBS as part of their business
e. Set up technical assistance for NHs to change the business model
f. Use smaller pilots to demonstrate feasibility of new business models

3. Invest in more accessible, affordable housing and community services

a. Create new, less burdensome regulations that support innovative congregate housing
b. Create Community Navigator Team to provide enhanced, personalized assistance
c. Create a committee for senior housing within the Housing Services Commission

4. Increase use of the PACE program model

Identify high acuity consumers and create formal pathways of referrals from the state to PACE.

5. Increase referrals to and use of palliative care at home

6. Focus efforts on the "old old" in NHs

Explore alternative care models for persons age 85+ who are "low care," ambulatory but frail elderly with a dementia diagnosis.

7. Develop an Accountable Nursing Home Pilot program

Consider new payment model that incorporates elements such as a new admission rate, quality multiplier, single bed incentive, and/or an all-payor performance bonus.

8. Have state meet directly with willing NH providers and associations to ask for feedback

9. Partner with high volume Medicare Accountable Care Organizations (ACOs) and/or Medicaid Accountable Entities (AEs)

10. Build on the current Medicaid AE pilot

Establish an LTSS AE program focused on the dual eligible population.

11. Establish different reimbursements for different levels of care

D. Delivery System, Provider, and Process Transformation

1. Replicate and promote the SASH (Support and Services at Home) model

Accelerate adoption of the model and measurement of results.

2. Invest in other promising population health models

Investigate models with community service centers sponsored by a health plan for members covered under an at-risk plan, and the Beacon Hill Village model such as Providence Village of Rhode Island. Encourage Medicaid recipients to join such models and/or pay for their membership.

3. Expand family caregiver supports

Specifically: (i) expand the state's Family and Medical Leave Act and temporary caregiver insurance benefits; (ii) expand caregiver training and education, and (iii) expand respite availability, including adult day programs outside of normal working hours and temporary stays in a NH or assisted living facility for periods of up to a week.

4. Promote care transition models

Promote evidence-based care transitions models such as the GRACE model (Geriatric Resources for Assessment and Care of Elders, Indiana University) or Care Transitions Intervention (Eric Coleman).

5. Tighten nursing home admission standards

Using Medicare Advantage plans as a model, examine legal and regulatory possibilities of increasing controls and clinical criteria for every NH admission and length of stay through a gatekeeper model.

6. Create multi-payor initiative(s)

Extend current Medicaid ACO model to dual eligibles or to LTSS. Start with one-sided (upside only) payments and gradually move to 2-sided risk with global payments for total cost of care and broad partnerships. Consider relaxing regulations and reporting burdens and allowing flexibility to manage the pool of money and distribute incentives.

7. Promote telehealth services

8. Promote or increase nursing home diversion

Divert consumers who are pre-eligible for Medicaid from facility care to less expensive HCBS by increasing investments in housing and in the broad range of community HCBS.

9. Expand HCBS workforce and access to geriatric providers

Target PCPs and other medical professionals for geriatric-sensitive training that includes community-based care options and dementia care. Work with MCOs to provide incentives for the training. Provide a path for certified nurse assistants from closed NHs to become part of the HCBS workforce.

Introduction

The Rhode Island Executive Office of Health and Human Services (EOHHS) Long-Term Services and Supports Evaluation of Rebalancing Strategies (the "Rebalancing Study") aims to identify recommended actions, activities, and policies to reform and rebalance the long-term services and supports (LTSS) system in the state. The *Rebalancing Study* comprised three major activities:

1. An initial Environmental Scan, to understand Rhode Island's current policies and activities around rebalancing the system and other states' mechanisms for change, activities, and impact
2. A Quantitative Study with focused data analysis to identify precipitating factors for individuals in need of or receiving LTSS in Rhode Island (pre-Medicaid and current Medicaid recipients) and to provide data to support recommendations
3. A Qualitative Study to engage stakeholders (e.g., advocates, providers, policymakers) as key contributors to the development of the initial and refined recommended actions, activities, and policies

This report summarizes the findings of the third activity, the Qualitative Study.

Methods

This Qualitative Study builds upon findings from the initial Environmental Scan, which was conducted by the Lewin Group (Lewin) and presented to the Rhode Island Executive Office of Health and Human Services (EOHHS) in August 2016. The Environmental Scan made preliminary findings about the state of LTSS and rebalancing in Rhode Island in nine policy focus areas, explored promising practices from other states, and summarized lessons learned and opportunities for Rhode Island to explore (see Appendix A for a complete list of Environmental Scan policy focus areas). From these nine initial policy focus areas, EOHHS selected three reform areas for further detailed inquiry through the Qualitative Study:

A. *Eligibility Process*
B. *Communication, Awareness, and Access to Information*
C. *Nursing Home Partnerships*

In addition to the three topics selected from the Environmental Scan, EOHHS requested that an additional focus group be conducted on a fourth, more broad-ranging policy focus area:

D. *Delivery System, Provider, and Process Transformation*

Stakeholder input for the Qualitative Study was gathered in two stages: key informant interviews and focus groups (listening sessions). Participants for the key informant interviews and focus groups were selected and recruited by EOHHS in consultation with the Lewin team. Participants were chosen based on their extensive knowledge of the current state of LTSS in Rhode Island, their senior positions in their organizations, and their ability to think broadly and creatively about rebalancing proposals. Organizations represented in the Qualitative Study included nursing homes, community providers, managed care organizations, elder care attorneys, other advocates, and policymakers.

Key informant interviews and focus group discussion guides were drafted by the University of Connecticut Center on Aging (UConn) in consultation with the other members of the Lewin Team [Lewin, Brown University (Brown), and the Faulkner Consulting Group (Faulkner)], and approved by EOHHS. Questions in each topic area sought stakeholders' feedback regarding current LTSS policy and practices as they relate to rebalancing, barriers to rebalancing, and recommendations to overcome barriers and promote rebalancing, including potential partners, budgetary impact, timing, and metrics to measure success.

Seven key informant interviews were conducted by telephone during the week of September 12, 2016 by UConn, Brown, and Lewin, and lasted approximately 60 minutes each. Four 90-minute focus groups on the topics selected by EOHHS were held in Warwick, Rhode Island and moderated by UConn between September 26 and October 7, 2016. Of the 51 persons invited to participate in a focus group, 23 ultimately attended. Three persons who participated in key informant interviews also attended one or more focus groups; one person attended two focus groups. In total, 27 individuals participated in a key informant interview, a focus group, or both. (See Appendix B for additional details on key informant interviews and focus groups by topic.) All key informant interviews and focus groups were recorded and extensive notes were taken. In addition, transcriptions were prepared for each focus group to aid analysis.

Key informants for the first three reform areas were asked for their opinions on the major issues in the selected topic that impact rebalancing, and for their suggestions on policy or practice changes that should be made. They were then presented with a list of preliminary recommendations on that topic that had been derived from the Environmental Scan, and asked for feedback on each idea and for their top three overall recommendations. For each of the top three recommendations selected, they were further asked to note potential partners, barriers to implementation, timing, success measures, and budgetary impact.

The focus groups on the first three reform areas were conducted in a similar way to the key informant interviews. In each, participants were asked to validate and add to extensive lists of key drivers, gaps or barriers inhibiting rebalancing in Rhode Island that were assembled from both the initial Environmental Scan and the key informant interviews (see Appendix C). Focus group participants then reviewed a list of recommendations also derived from the Environmental Scan, identified practices from other states, Rhode Island initiatives, and key informant interviews. The fourth focus group, on the broader topic of Delivery System, Provider, and Process Transformation, was conducted in a slightly different manner, since no key informant interviews had been held on that topic. In that group, a list of "key drivers inhibiting rebalancing" was discussed and validated before seeking input on recommendations (see Appendix C). Several recommendations were added by participants in each focus group, and participants prioritized the top 3-5 recommendations to discuss in more detail, identifying specific partners, barriers, and strategies.

Summary of Recommendations from the Qualitative Study

This analysis summarizes the combined stakeholder input from the seven key informant interviews and four focus groups, enumerating the recommendations made and additional considerations discussed including potential partners, barriers, and strategies for each of the studied categories:

A. *Eligibility Process*

B. *Communication, Awareness, and Access to Information*

C. *Nursing Home Partnerships*

D. *Delivery System, Provider, and Process Transformation*

Potential partners and barriers are listed by recommendation in Appendix D.

Supporting direct quotes from stakeholders are included in the discussions below, and are marked with a notation to indicate whether they came from a focus group transcript [FG] or key informant interview notes [KII].

To fully reflect the richness and diversity of discussion, no attempt has been made in this document to edit the list of recommendations made by key informants and focus group participants or to editorialize on the discussions held. Rather, the Lewin team has used this feedback together with other Rebalancing Study activities and its own knowledge and experience to form the team recommendations contained in the final deliverable provided under separate cover to EOHHS.

A. Eligibility Process

1. *Implement presumptive financial eligibility for Medicaid for all Home and Community Based Services (HCBS) waiver programs and provide services while application is pending*

A presumptive or expedited eligibility process would enable individuals in need of community-based LTSS to begin accessing benefits while financial eligibility verification is ongoing. A delay in obtaining community-based services, such as adult day services, can cause individuals in crisis to enter a skilled nursing facility, which often offers presumptive eligibility. Under the current 1115 waiver authority, for new LTSS applicants, Rhode Island may accept self-attestation of financial eligibility for up to 90 days (not yet implemented) and applicants would still receive some LTSS while awaiting final determination. The Centers for Medicare and Medicaid Services (CMS) agreed to cover the claims even if the person were denied Medicaid eligibility. The recommendation is to fully implement this policy in the waiver and expand it to all HCBS programs.

It's no secret that it takes a while, even the apps we call easy, it takes a couple of months at minimum to process. Complicated ones can take 6 months or more. In the meantime, the client is not getting any help. If they're lucky they may have a visiting nurse or family. The DEA [Division of Elderly Affairs] Co-Pay for non-Medicaid, sometimes people are on that program before they're approved. Some start in Co-Pay and then apply for Medicaid because more cost-effective and want other LTC services. But in situation where they can't do that because they are on community Medicaid, so we can't put them on Co-Pay, you can't be on both at once because that's double-dipping. We'd have to look at a nurse, or family – if family can't afford private pay, there's no service for them. [KII]

Allow expedited eligibility for HCBS. In a crisis, [people] would go to a nursing home while Medicaid application is processed. [We've] had an idea since 2013 to have presumptive eligibility and be able to go to adult day care instead of a nursing home – to date the state has not implemented that, all these ideas that have been approved by the federal government have not yet been implemented. [KII]

2. To support expedited eligibility, increase assessor capacity to prevent delays in getting a functional assessment

If presumptive eligibility is established, current staffing levels for functional eligibility assessors will be insufficient and may increase existing wait times. Specific recommendations were to (i) expand the types of medical and other professionals who can do assessments; (ii) train hospital discharge staff, managed care organization staff, or other roles as assessors for functional eligibility; (iii) co-locate functional eligibility assessors in hospitals or other medical settings, which would eliminate the need for a separate assessment; and (iv) expand the role of the co-located eligibility assessors to assist with care transitions, helping the individual connect with HCBS and Medicaid eligibility.

I don't know if things have changed but at least the complaint that we have heard repeatedly is people have to wait for the assessment. There aren't enough contracts with various agencies to [do assessments] … there's waiting time just to get the assessment. And maybe more people have signed on since then but the people, the organizations that are doing the assessments; there just weren't enough at the time so… [the wait] was too long. It was too long. [FG]

3. Create a true single waiver system and/or standardize requirements for level of care and financial eligibility across all ages and populations. Eliminate variable rules for legacy waivers/programs within the 1115 waiver

Although Rhode Island has had an approved Section 1115 Global Medicaid Waiver since 2009, it does not operate as a true global waiver, since the state has retained the rules of the legacy waivers that existed prior to the 1115 waiver, each with differing requirements for level of care and financial eligibility for different ages and populations. Adoption of this recommendation would also eliminate the separate Social Security determination standard for those under 65 who are receiving Social Security Disability Insurance (SSDI).

I think that to just look at [over] 65 and not [under] 65 is kind of short-sighted because people, it really comes down to people who have chronic disease and have a health incident that causes them to be in need…and also part of the Affordable Healthcare Act is that whole Mental Health Parity Law, so I think that we should begin to really think about it as a whole group, and I think that's a big, will be a big shift based on the way we operate currently. [FG]

4. Use one standardized assessment tool and assessment process to determine level of care and functional eligibility for all populations, regardless of age or type of disability

Currently many different assessment tools and processes are in use, leading to delays or prevention of access to services. While no specific uniform assessment tools were recommended, it was noted that several exist and are used in other states. Informants gave examples of recommended ways to streamline the assessment process: (i) eliminate Primary Care Provider sign-off for functional assessment approval; (ii) reduce the number of necessary steps and hand-offs required; (iii) redesign the eligibility application form to be more user-friendly for the consumer and family; and (iv) reduce burdensome documentation such as six months of bank statements, which could be reduced to three.

Our case managers go to the person because most of our clients are what we say are homebound, so they're either, in their own home or in assisted living, and we go to them to assess them. The level of care requirement where we, well, I won't get too much into that piece, but the doctor has to fill out the form for the level of care, what's known as, it's called the PM1 that's the form that the doctor has to fill out ... but of course the client has to be seen. The patient has to be seen within a recent period of time. We run into trouble if the client hasn't been seen. So of course it requires a visit to the doctor, because if that patient hasn't been seen in a while it's going to raise eyebrows. [FG]

Maybe need doctor to write a few sentences that the diagnosis is XYZ and yes, they need help in the home. It's hard to fill out bathing, dressing, etc. You have to stop and think. Some things are subjective, you're seeing hundreds of patients, the client says they can do it, they only see them a few times a year, [and] they might be doing well on a particular day. Financial piece may be put on hold if medical piece not received. [KII]

One of key issues [holding up eligibility] is obtaining info needed for the applications, particularly with the elderly clients we serve here. Even though it's an elder service unit, we deal with some clients that aren't necessarily elderly but they qualify for programs because of their diagnoses, i.e., mentally ill, but qualify for our programs because of our contract with DEA, you could be 20 years old and still qualify. We have clients in our 30s. It can be difficult for CMs to obtain information for the long term care application, i.e., you need something as simple as an ID. Some of the people who are homeless, they may not have an ID. [KII]

5. Develop a fully electronic online waiver benefit and financial eligibility platform – from screening to application to determination – and streamline the exchange of functional and financial eligibility determination information among the various units involved

The new Unified Integrated Eligibility System (UIES) tracks transfer of forms and uses ticklers to enhance accountability, but does not provide a fully electronic system for eligibility application or determination. Specific recommendations were to (i) develop and maintain a single portal/ online benefits screening and application tool; (ii) allow applicants to complete the entire application process online, including answering supplemental questions and uploading documentation; (iii) set short standard turn-around times for processing each step of the eligibility determination, incorporating these turn-around times into UIES; and (iv) develop and maintain a shared electronic system for LTSS functional and financial eligibility.

> *Wouldn't it be nice to have an… electronic transmission of information from a long-term care unit to the Office of Medical Review or whoever does an assessment? I don't know the answer to that, but there seems to be a lot of the fragmentation comes from we've got long-term care units sitting in Providence or wherever. They do some initial work. They're responsible for financial eligibility but they, after they get stuff, they ship it off to Cranston, right? That's OMR. And sometimes OMR transfers it to the Medical Assistance Review Team, more paper going, and meanwhile long-term care sits waiting for things to happen. [FG]*

Participants noted the state should aim to eliminate as much paperwork as possible to avoid passing paper back and forth between the functional and financial eligibility units.

6. Increase the community Medicaid personal needs allowance

Rhode Island's current monthly personal needs allowance of $923 for a Medicaid beneficiary residing in the community is less than half the median amount of $1962 in all states. Many participants suggested that it is a barrier to community living and recommended an increase, which would be an incentive to community living.

7. Integrate or coordinate Neighborhood Health Plan (NHP) with Rhode Island's Medicaid billing and eligibility system at EOHHS

Currently the eligibility and billing system of the EOHHS Medicaid programs and Rhode Island's major MCO, Neighborhood Health Plan, are held in different databases; each uses its own processes. This makes it especially difficult for providers to bill and get paid for services. Coordination of these systems would increase the efficiency of the NHP system and reduce burden on providers.

> *I think that the recommendation needs to talk about this outsider's sense of a disconnect between eligibility and Neighborhood Health Plan. You might be, you become eligible for a program first but there's a… real disconnect when the major managed healthcare plan for the state, which is Neighborhood Health Plan, when people move over to that system and it's a completely different database. It's a completely different billing process. There isn't a clear notification of when that happens, which puts providers in a really tough spot because they try to bill one side and it's not right, and then they try to bill the other side and it's not right, and then there's that pile of paper that [name] just mentioned that hasn't quite moved from one station to the next station, or hasn't been moved in its entirety, and it's really… It's such a different system than DEA, because the DEA case managers, they can get more involved with the billing. It seems more cohesive, I guess. With Neighborhood, it is so different… It's inefficient, and it's hard to get answers. [FG]*

8. Evaluate the UIES after 3-6 months to understand the implementation of the program from various vantage points and respond accordingly

Participants noted many issues with the roll-out of UIES, and suggested that the state would benefit from a formal evaluation of its implementation with wide stakeholder participation to understand the implementation of the program from various vantage points. This evaluation, suggested to be conducted within the next several months, can pinpoint issues and formulate a plan to resolve them through mid-course corrections. Participants suggested including focus groups with diverse stakeholders as part of the evaluation.

B. Communication, Awareness, and Access to Information

1. Ensure a neutral, impartial resource for LTSS information, independent of the state, for persons regardless of income

Participants noted that a state-run information hub may stigmatize the resource as only for low income/Medicaid. They also noted the importance of including (i) comprehensive, reliable, up-to-date information that does not "sell" the consumer products or services and (ii) information on all LTSS options, both publicly financed and private pay, with expanded support for the pre-Medicaid population (e.g. private case management, reverse mortgages, elder law attorneys, life insurance, dementia care, adult day programs). This recommendation could be accomplished through THE POINT (see recommendation #2 below), or through other means.

> *The state needs to change its mentality. Instead of leaving people on their own until they become Medicaid eligible, the state needs to provide the assistance to people to make the right choices with their resources so they can continue to be functioning citizens of the community in the community. [KII]*

2. Leverage THE POINT as a resource for all seekers of LTSS information (including consumers, hospital discharge planners, case managers, community social workers, and family caregivers) by increasing its capacity to provide information and improving access to its services

The predominant focus of most of the stakeholder input on this topic centered on the potential for THE POINT to become, or substantially contribute to, a No Wrong Door network of LTSS information for Rhode Island. Due to the wide-ranging and robust feedback, significant detail

about discussions and recommendations on this topic is included below, divided into sections on increasing capacity and improving access.

a. Suggestions for increasing capacity of THE POINT include the creation of a central location/website/telephone line where all consumers and caregivers can go for information. Although THE POINT is already in place and envisioned as a central source of information, it is currently under-resourced. Information is incomplete or out-of-date and staff insufficient for demand.

> *We would love to stay with our callers longer, but with 4 staff and 4000 contacts a month, it's not always possible. [FG]*
>
> *THE POINT has lost its engine, not sure why, they're so short-staffed they can't meet with us to have a conversation. I'm concerned about identifying them as a key resource when they don't have the capacity. [KII]*

Key activities included:

i. Create an interactive website for THE POINT dedicated to information for older adults in Rhode Island. Identify best practices for Aging and Disability Resource Center (ADRC) websites and procure/develop/build new website. Make THE POINT "a *travel agency for the journey of aging"* [KII]. Update and add content, and automate resources that are currently paper-based into a searchable database by topic/type of service. Model centralized website after the 2-1-1 website, with links to benefits screeners and chat and text features. Consider tying THE POINT website directly to 2-1-1- site and allow agencies to update their own information.

ii. In addition to 2-1-1, partner with community action programs, senior centers, regional POINTs, case management agencies, HCBS providers, managed care organizations, state employees, and acute care providers to represent as many doors as possible in a No Wrong Door network. Streamline and standardize training for all No Wrong Door partners on person-centered counseling and HCBS options.

iii. Allow THE POINT access to and integration with the state's system including eligibility.

> *It would be a tremendous help if [THE POINT] had access to someone's Medicaid record, and that's something we've talked about quite a bit because a lot of times individuals do not know if they have Medicaid or not. [FG]*

iv. Increasing THE POINT's capacity as recommended will necessitate additional funding for staff and training. Therefore, suggestions included:

- Fund additional staff to provide enhanced options counseling for those who don't qualify for Medicaid.
- Train staff on counseling not only for state benefits but also for private pay services.
- Fund case management agencies to do home assessments and counseling for those who do not qualify for state services.

- Provide state funds to maintain THE POINT, including web-based resource capacity and ongoing outreach to increase participation.
- Given the large number of older veterans in RI, increase the capacity of THE POINT to make referrals to VA programs, and vice versa.

> *Long-term services and supports issues are not generally things that can be solved just by throwing money at them, but this is actually something that can be solved with throwing some money at it. Doubling the staff, and there's a great Statewide network of POINTs, and if money were spent to beef that up, and then communicate the fact that it's there, and that would just, that would solve a lot. [FG]*

v. Co-locate staff from the long-term care eligibility offices in THE POINT programs with the highest demand to assist in preparing Medicaid eligibility applications and with the state-mandated person-centered counseling service to decrease fragmentation experienced by consumers.

b. Suggestions for improving access to THE POINT were also numerous, although participants cautioned that building capacity should come first, so as not to increase demand that cannot yet be met.

i. Promote a robust series of No Wrong Door entry points that lead to the centralized information source (e.g. community centers, senior centers, adult day centers, community action agencies, managed care organizations (MCOs), other providers, churches, senior housing, civic groups, non-profit organizations, elder law attorneys).

ii. Provide customer service performance standards in contracts: Monitor metrics including timeliness, standards of responsiveness, and client/caregiver satisfaction.

iii. Promote THE POINT through multi-media awareness campaign and advertise person-centered counseling program and other programs for older adults – make "THE POINT" a recognized household word. Ensure a consistent outreach – information from sporadic campaigns will not be remembered when needed.

> *THE POINT needs to be a household word, and THE POINT also needs to be capable of being a household word. [FG]*

iv. Clarify in messaging that THE POINT is not a state agency.

> *If you contact DEA, if you call their phone number, you're getting THE POINT…When they're on the phone they think they're speaking to a state employee, so that's very confusing…When you tell them no, I'm the United Way, they don't understand…And no, we're not going to remove you from your home. We have to say that a lot. [FG]*

v. Standardize the messaging about LTSS statewide. Work with MCOs to ensure their marketing materials are consistent with the standard messaging.

3. Conduct community education campaign to make people aware that community LTSS exist, and standardize the messaging about LTSS statewide

Participants noted a pressing need to encourage potential LTSS users, families, and providers to think about LTSS earlier, before a crisis hits. To reach older consumers and those who are dually eligible, suggestions included:

i. Using informal marketing strategies, such as church bulletins, radio, and bus stop billboards

ii. Emulate the on-the-ground marketing of the Providence Village, utilizing local businesses to distribute written materials and going back frequently to make sure the materials are always there.

iii. Go to health clubs, employment settings, churches, and civic organizations to reach people in their 30s and 40s.

There's a pretty limited awareness out there that home and community-based services and supports are even a thing you can look for, so it's not even a question in many cases that you can't find the information, it's that you don't even know that it's information that you should have. [FG]

We do a market analysis on how consumers learn about our services, a lot of it is boots on the ground – people don't tend to seek out websites, caregivers may, but they rely a lot on casual hand-to-hand marketing techniques, i.e. information through their churches. Rhode Island is 90% Catholic; distribution through church bulletins is very effective. Radio is very effective. It's not uncommon for physicians' offices and hospitals to advertise services on the radio because we've done our market research. It's not very sophisticated. But that's how people learn about health care options and make decisions; it's through these more casual techniques. Believe it or not, the billboards, especially bus stop billboards, are big. You get a lot of drive-bys, mostly dual eligible, so they may roll by in public transportation. Or if you're a younger older adult, they may rely on the bus system. Bus billboards are very popular. We do inserts in the newspaper. When people know there is a useful insert, paper sales will go up. There are local television spots that are a real hotbed for communication for local healthcare orgs. [KII]

The marketing budget has to be a consistent annual, same amount every year. The information about THE POINT is as important as the information that THE POINT provides... Buses are driving around with 462-4444 on them, and it's just a part of the landscape… You know, it just drums in and it's just always, always, always there instead of thinking it just has to be a one-time thing. [FG]

Further, participants suggested standardizing the marketing materials from MCOs and creating marketing materials targeted at diverse stakeholder groups, such as respite programs for family members or caregivers. They recommended that given the MCOs approach to publicizing Medicare, the Medicaid office emulates these educational efforts to disseminate LTSS information.

The managed care organizations for Medicare can be really helpful in helping people think differently about how they're going to be more planful for their aging and employ those supports. [FG]

I think we've learned that Medicare is really effective at educating consumers to what their options are… And so we may want to emulate some of that…communication. The reason why people know a lot about nursing homes is not just because it's on the front page. It's not on the front page of the Journal every day. It's because they get information from Medicare…What's the methodology that the Feds have used as a communication strategy that I think we may not have picked up on? [FG]

4. Promote Program for All-inclusive Care for the Elderly (PACE) more widely

Many participants noted that the PACE program in Rhode Island is very effective at caring for people in the community who would otherwise qualify for nursing home (NH) admission, but is not as well-known as it should be, and could be promoted more effectively through state agencies and providers. (See further discussion and recommendations concerning PACE under Nursing Home Partnerships below.)

> *PACE has been front and center in the state strategy, but they do not promote the PACE program the same way they promote other integrated care initiatives. The state could be held to a higher bar as for promoting the option of PACE. [KII]*

5. Improve awareness and education regarding HCBS among care transition professionals

Hospital discharge planners and some care managers may rely on NH admissions due to lack of awareness specifically about HCBS alternatives. Working with hospitals and care management agencies to increase awareness of alternatives, such as adult day centers, can keep people in the community longer.

6. Clarify each HCBS program's specific rules, and post this information online in one visible, easy-to-find online site (e.g., THE POINT, if revised as recommended)

There is a need for clear explanations, in layman's terms, of the rules, services provided, financial and functional eligibility criteria, and application process for each HCBS program or population. Participants suggested creating direct links to this webpage from all state health, community services, disability, and aging-related websites, and keep it up to date.

> *And, basically, there's just a complete lack of clarity as to what the financial criteria are. In other words, we have this global waiver program but we still think in terms of the DEA waiver, the Medicaid waiver, the RIMFAC waiver… I can tell them what the rules are with a nursing home, but I can't tell them what programs they're eligible for, what their financial criteria has to be… And so the default is with some, if you go to a nursing home, you know what the rules are. You know there's going be a medical evaluation at some point. You know if you have a spouse, there's a community spouse resource allowance. You know how the income gets allocated…but you don't know from a financial perspective on the waivers – much less do you know what the services are going to be on the waivers. [FG]*
>
> *The issue between institutional care and community-based care is that a nursing home can give you a pamphlet that contains all services provided 24/7, but we cannot give you an easily understandable and maneuverable package for community-based services, which may contain 12, 16, or 24 different components. No one is responsible for coordinating all that but you or your family. [KII]*
>
> *In general, try to improve the description of what the LTSS are, and the income eligibility for those programs. I think it's especially hard for people who may need to private-pay for any of the services. It's not clear to them what the eligibility guidelines are. [KII]*

7. Include more quality measures and "standards of responsiveness" in contracts with providers (e.g. home care, adult day) and make available to consumers

Participants noted that persons seeking HCBS have a difficult time selecting high-quality providers due to lack of data about HCBS organizations comparable to data available for NHs. They suggested that the state develop a quality measures/data book or report card on provider and payor performance and make it available to consumers and providers. Suggestions included use of existing national measures and focus on integrating providers, such as assisted living facilities, which do not have the same regulations as NHs.

> *I know the state has been moving towards including more quality measures in their contracts with payors or providers. Not quite there. What I envision is that the state will be producing a data book back to consumers and providers which essentially is a public report card on provider performance and payor performance. The industry holds itself accountable. They know that the five star rating is publicized. Once the state evolves to a more predicable set of performance measures and becomes a public reporting mechanism, a lot of this noise will go away. I hope the state develops a QM [quality management] strategy to get from a more fragmented approach to a more integrated method whereby you're able to publicly communicate performance and outcomes to consumers as well as providers. That may necessitate some legislation, some consumer satisfaction legislation that home care agencies have to use the same survey tool, hospitals have to use same, etc. Do you add adult day to that bill for example. Focus more on care delivery system than whether Neighborhood is paying their claims or not. [KII]*

8. Reduce burden on community partners by establishing longer-term partnerships and streamlining the contracting process

Many community partners who contract with the state to provide HCBS services experience frequent re-bidding for contracts and a burdensome contracting process, even for small contracts. A less burdensome process and multi-year contracts would create greater stability for agencies, which the state relies on to provide HCBS and education.

> *I know that there are state and federal regulations for RFPs. But it's not productive every 2-3 or even 5 years to go out with a request for a proposal that might result in changing an organization you've been investing in for 5 years. Five years is not enough to develop a system of care for aging or a system for information. The state needs to give some thought to how they work with companies that are doing critical pieces of information or service for them. It's not like bidding on a caterer. I get the whole point of having competitive bids. But I do think this is more about establishing partnerships between state and community orgs that are going to work together on a long-term basis to make sure we are using our resources the best we can in Rhode Island and create a good environment for people to live and age. [KII]*

C. Nursing Home Partnerships

1. Reduce statewide bed capacity

Participants agreed that a statewide rebalancing strategy is unlikely to be successful without an overall reduction in NH bed capacity. There were numerous suggestions for furthering that broad goal and recognition that it will most effectively be accomplished through industry partnerships. At the same time, there was also acknowledgment that major culture change will be necessary to reverse the existing bias toward NH placement in Rhode Island.

> *It's very easy and, again, there are… these are folks who could do very well at home, but… because it's so easy and accessible to get a bed; it's easier for the case managers and families to transition them there. If there are fewer beds, they're left to say, "okay, now I have to figure out a plan to get them home." It's a little more effort, but I feel like it's that concept if you build it, they will come… They actually book the rooms ahead of time before they even know they're going to need them. And so I do believe we have an overcapacity even on the skilled side. [FG]*

The broad goal of reducing NH bed capacity generated significant discussion on a wide range of strategies to achieve that goal. Although some are potentially contradictory, all suggestions discussed are summarized here to display the broad range of thinking on this topic.

a. Continue moratorium on NH beds.

b. Target facility closures and/or delicensing of beds through state buyout, with consideration for regions that may be over-bedded compared to demand. Ensure that appropriate HCBS and workforce are available in regions where beds are delicensed. Not all participants agreed with the recommendation to buy back beds.

> *Look at which geographic areas are over-bedded – Northern, East Bay, Greater Providence County; they are competing for a diminished population at this point. One option is to buy the nursing home operator out and keep the beds (250-300 beds) out of service – de-license the facility; or, de-license the beds and leave the buildings for the nursing home operator to repurpose… I think the most effective way would be to say we want to buy back 250-300 beds and take them out of service. I think in year 1 you have that expense, but after year 2 that would fall to the bottom line… Some people may be willing to get out of operating nursing homes. Others may think to give up license and convert to Medicaid assisted living. [KII]*
>
> *I don't think it's a great idea for the state to buy out beds. Other states have developed processes for high-quality providers to buy beds from lower quality providers – such a process would require state and regulatory change because the states own the beds and providers are granted licenses for them. [KII]*

c. Maintain beds in the homes with better facilities and higher quality care. To discourage closing of higher quality NHs, create NH quality programs and publish indicators such as length of stay, staffing ratios, etc.

> *We could set up quality programs with the SNFs to incentivize them for shorter length of stay, keeping patients in the community longer. There are actually models that we can do that. The challenge has been it's very difficult to find a correlation between utilization metrics and quality metrics. There really isn't any, and that's been the challenge. [FG]*
>
> *You always think of those providers whose physical plants are at the worst that they would be the first to go, so you would weed the marginal providers first. Not sure if that is what would actually happen. [KII]*

d. Utilize flexible licensing in which any bed could be used for any level of care, within the strictures of state and federal Medicare/Medicaid regulations.

e. Encourage incentives for conversion of rooms from double to single, and increase Medicaid rates for private single-bed rooms, which would not only reduce beds but also increase residents' quality of life.

> *Reducing capacity is tricky, cutting industry is not good for residents. Incentives to convert to single rooms where providers get a higher daily rate for private room would have more buy-in. Medicaid rate is $200 a day right now for single or double room. Industry has evolved to primarily have double rooms. Convert to single room while making financially viable would have a lot of buy-in from people in the industry, policymakers, etc. aligned with priorities within the industry. [KII]*
>
> *You wouldn't have to convert the whole facility to private rooms. Economically I think that would be hard to do with the costs (mortgages, taxes, etc. would be prohibitive). But, you could encourage converting 25-30% of beds to private rooms. I think there are options out there; I think people might be willing to entertain that. [KII]*
>
> *Next fiscal year on a standalone basis, the idea of nursing home incentives to convert to single rooms, bed buyouts but more controversial, single room conversion could be tested through state budget to see what kind of buy-in there is for that. [KII]*

Allow providers to buy beds from other providers as competition may reduce some beds.

> *I almost think the state should develop a way for the nursing home market to solve the issue themselves. [KII]*

2. Expand nursing home business models

There was significant discussion of ways that NHs could change or expand their business models as they reduce beds dedicated to long term care, along with state incentives. Many ideas involved adding HCBS services or repurposing beds. Recognizing that any change must work within the requirements of the CMS HCBS Settings Final Rule[1], many suggestions were made for further exploration. As with the recommendations for reducing bed capacity (see #1 above), suggestions discussed for expanding NH business models are summarized here to display the broad range of thinking on this topic.

a. Consider repurposing whole NH or empty wings in NHs with lower occupancy. Entire buildings could be repurposed to assisted living, independent living, other community housing.

[1] CMS HCBS Settings Final Rule, which restricts Medicaid payment for HCBS provided on the same premises as facility care: See https://www.medicaid.gov/medicaid/hcbs/guidance

Instead of allowing willing buyers to keep beds in service, encourage growth of Medicaid assisted living to repurpose beds at a greater reduced reimbursement rate. Less variety services and staff needed as compared to SNF. [KII]

Initial cost and subsequent savings, if you're going to buy back licenses, that's going to cost an initial amount of money, like $20 mil (throwing out a number), reduce by 250 beds, my belief is that by years 2-4 that money is a savings. If you repurpose buildings to provide care that doesn't currently exist, ultimately results in savings. Upfront costs will be relatively high, but potential for real cost saving down the road. [KII]

b. Utilize entire NH or empty wings for behavioral health (BH) care, within the context of applicable CMS reimbursement rules. In each region, closed NH or wings could be repurposed to supportive community housing with onsite BH services. Alternatively, convert NHs to specialized BH facilities to provide care for those with both BH and skilled nursing needs.

Maybe the state could also use empty nursing home wings to create specialty behavioral health units. The behavioral health population is aging. The state needs to help get the behavioral health support that the clients need that is outside of nursing home support care (e.g., psychiatrists, training for staff). These individuals may need one-to-one staffing – the state could offer a Medicaid add-on to care for these individuals for more intensive staffing and resources. [KII]

There are other opportunities for mental health services. Converting to mental health services and residential services for the mental health population. [KII]

c. Encourage expansion of respite beds and services within NHs, such as short term or flexible respite models to relieve family caregivers – offering day, overnight, or weekend options.

d. Create incentives for NHs to include HCBS, such as home health care and adult day programs, as part of their business in space freed up by closed beds. Develop extended adult day programs, offering evening and weekend hours.

e. Set up technical assistance for NHs to change the business model.

If there's a converting to independent living, if there's technical assistance for a nursing-home operator to be able to do that, I think that could be helpful. [FG]

f. Partner with NHs and use smaller pilots to demonstrate feasibility of new business models.

I would strongly encourage people to approach anything they undertake sort of using the quality-improvement model and do small pilots that you can sort feel the texture on and be able to make the midcourse corrections and work very closely with the people that are so embedded into the system and then grow it. [FG]

3. Invest in more accessible, affordable housing and community services

Participants cautioned that beds or facilities should not be closed before sufficient community housing and services are in place, and recommended working with facilities to ensure the availability of both in order to make discharges easier and safer.

> *Having sufficient community opportunities out there is going to help drive the success of keeping people in the community, not necessarily in their existing housing but in the community in some housing. Simultaneously if you repurpose some of these facilities into living circumstances for some of these folks that offers opportunities for them to maybe go from a SNF where they have almost gone back to their prior level but not enough to go home, to go [to] these facilities where they can live a fulfilling life. These two ideas hand in hand would go a long way, and make everything healthier. [FG]*

Specific suggestions for investing in community housing and service infrastructure and encouraging its use included:

a. Create new, less burdensome regulations that support innovative congregate housing.

b. Create Community Navigator Team to provide enhanced, personalized assistance to walk the family/consumer through the whole process of obtaining community services – not just give out agencies, numbers, and websites. One model suggested by a participant is the service provided by neonatal intensive care unit teams for parents of premature infants. Look for grants to try new worker and volunteer models.

c. Create a committee for senior housing within the Housing Services Commission.

> *Housing Resources Commission is supposed to have a committee for senior housing, but no one is on it. Not sure how to get their buy-in. Need to connect the EOHHS to talk to housing world like how HHS talks to HUD at the federal level. [KII]*

4. Increase use of the PACE program model

The PACE model, in Rhode Island and nationwide, was cited as a good example of the use of case management and bundled services to keep high acuity consumers at home and assist their transition back to community if they go into NH. PACE provides all around supports for community living; gives providers quality incentives; enrolls consumers with high acuity levels; contracts with Medicare/Medicare; and cannot disenroll a person if he/she goes into NH. In addition to suggesting that PACE be promoted more widely (see recommendation under Communication), participants recommended that the state take additional steps to increase its use by identifying high acuity consumers through established targeting criteria and creating formal pathways of referrals from the state to PACE.

> *PACE program remains underutilized. Enrollment has been relatively stable; they do a good job of keeping people in community and out of nursing homes. If there's a way to ID candidates that will meet state eligibility criteria and direct people towards PACE, it could be helpful. PACE has to do its own marketing to build own referrals; there's no formal pathway through the state like Neighborhood has. [We need] screening models to flag people for PACE. [KII]*
>
> *Increasing PACE can be done in this current fiscal year, if there's an organized way for state protocols to increase referrals, etc. [KII]*

5. Increase referrals to and use of palliative care at home

Participants noted that many individuals are admitted to NHs who could otherwise be cared for in the community if they had access to palliative care at home.

6. Focus efforts on the "old old" in NHs

Participants discussed alternative care models for the substantial number of persons age 85+ who are often "low care," ambulatory but frail elderly with a dementia diagnosis. Participants suggested that the state create care settings as specialized assisted living or NH wing/unit for those who lack informal supports or family members, which can make it more challenging for them to be in the community.

7. Develop an Accountable Nursing Home Pilot program

Many participants expressed interest in exploring a pilot program in which the state would certify a small number (<10 perhaps) of "Accountable NHs" who meet specific standards and are willing to participate in a new payment model that might incorporate elements such as a new admission rate, quality multiplier, single bed incentive, and/or an all-payor performance bonus. The all-payor performance bonus could include a withhold and/or bonus for all-payor, facility-based performance on key metrics such as reductions in avoidable emergency department use, reductions in average length of stay, or percentage of admissions with stated interest in returning to community doing so within a certain number of days. Participants noted that specifics would need to be worked out with the NH industry.

> *Accountable Nursing Facility Pilot Program would be good, [but] I get nervous when hearing about payment withholds that you have to earn back based on performance incentives, since haven't you already made the money? [KII]*
>
> *You'll want to be very transparent and careful about all-payor performance system – trade associations, get their buy-in with provider representatives, nursing home providers. Use transparent organized process where it's sort of mutual – not just 'this is what we are going to do' but talking about different ways to move forward and different measures and discussing pros and cons of each of those. Would suggest a workgroup, formal or informal. [KII]*

8. Have state meet directly with willing nursing home providers and associations to ask for feedback

Many participants emphasized that any rebalancing proposal, not only the Accountable Nursing Home Pilot discussed above, should be discussed directly with NHs and their representatives to gain their perspective and buy-in.

> *Putting these people at the table and asking for feedback, and then you can proceed accordingly. I think it would be a very welcome and refreshing approach to have some folks from state government to come meet with any willing provider and the associations and say, 'Let's talk about this,' and we could move this along, maybe I'm an optimist, rather quickly. [KII]*
>
> *Once the provider community sees and believes you want them at the table, they will be interested to engage. [KII]*
>
> *The state needs to open up conversations with the providers that have census issues and talk to them about how to make use of their empty space. [KII]*

9. Partner with high volume Medicare Accountable Care Organizations (ACOs) and/or Medicaid Accountable Entities (AEs)

In order to encourage effective transitions of Medicare enrolled who are not yet eligible for Medicaid (Medicaid pre-eligible), the state should encourage partnerships, which might include an all-payor bonus and standardized screening tool.

> *I've encouraged [NHs] to try to position themselves to work with ACOs for that reason – [it's a] burgeoning trend, they'd get more referrals from the ACOs, and they would commit to working with them to ensure efficient transition to community. There would be downward pressure on length of stay, but could they make up for it with increased referrals. I think that is a legitimate idea. The state wasn't too interested earlier – AEs just got up and running earlier this year. Take time and don't rush it, especially since just rolling out ICI [Innovative Care Initiative] with Neighborhood. Don't just throw things at the wall and see what sticks. [KII]*

10. Build on the current Medicaid Accountable Entities (AE) pilot

Participants encouraged the state to establish an LTSS AE program, focused on the dual eligible population. The program should be designed to encourage the development of providers with an integrated LTSS continuum of care and a shared commitment to reducing the cost and increasing the quality of care for this population.

11. Establish different reimbursements for different levels of care

Participants noted that state reimbursements to NHs could usefully differ by level of care, but lower reimbursements should come with less regulations and lower staffing requirements.

> *Different reimbursement for each LOC, you could potentially offer within the same nursing home, three levels of reimbursement based on a population assessment (i.e., ICF1 and ICF2). Lower reimbursement could also come with fewer regulations and less staff. A single rate of reimbursement will cause facilities with higher-performing operations to lose a dramatic amount of reimbursement that is buried in labor, capital costs that cannot be cut back. [KII]*

D. Delivery System, Provider, and Process Transformation

1. Replicate and promote the SASH (Support and Services at Home) model

A proven model in VT that will be piloted at St. Elizabeth's Community in RI, SASH coordinates case management, health, social services and housing for persons living independently at home, and may prevent or delay NH admission for Medicaid eligibles as well as pre-Medicaid. Participants recommended accelerating adoption of the model and measurement of results.

> *It's a way to hot spot people that are low income and have chronic conditions and may or may not be Medicaid eligible yet; most of them [are] Medicare eligible... It's a model that definitely is relatively inexpensive…it's about $1000 per member per year, which is a pretty low price for the return on investment. [FG]*

2. Invest in other promising population health models

Participants noted that other population health models from other states could be adopted or expanded in Rhode Island and gave the following examples for further exploration:

a. Models with community service centers (with or without housing) sponsored by a health plan for members covered under an at-risk plan. The center may include basic health care, dining center/meals, and other programs and activities, funded in part by membership fees and in part by a significant investment by the health system. One example is the Lake Erie College of Osteopathic Medicine (LECOM) Institute for Successful Aging partnership with a retirement community in western Pennsylvania.

b. Beacon Hill Village model such as the new Providence Village of Rhode Island. The state could encourage Medicaid recipients to join such models and/or pay for their membership.

> *Could Medicaid kind of encourage people to join something at say like Providence Village?...And it's only $40 a month. Two rides with a taxi to take you somewhere is $40, and you could ride every day…so is there a way to bring the Village membership into the Medicaid system as an approved service? [FG]*

3. Expand family caregiver supports

Informants recommended numerous expansions of caregiver support including: (i) expansion of Rhode Island's Family and Medical leave Act (FMLA) and temporary caregiver insurance benefits, (ii) caregiver training and education, particularly on recognizing what is and is not an emergency, and (iii) substantial development of expanded respite availability, including adult day programs outside of normal working hours and temporary stays in a NH or assisted living facility for periods of up to a week. Participants noted that some private insurers, even though they do not consider caregivers to be their "members," nevertheless are flexible in paying for caregiver services that will allow the member to remain at home and avoid more costly care.

4. Promote care transition models

Noting that transitions among levels of care are the most fraught with risk of deterioration and institutionalization, promote evidence-based care transitions models such as the GRACE model (Geriatric Resources for Assessment and Care of Elders, Indiana University) or Care Transitions Intervention (Eric Coleman).

> *There's obviously a lot of social issues that can be dealt with there, but there are also medical issues … how do we simplify things so it doesn't happen again?...You send them home, and what you're sending them home on is no transition, no discussion, no fixing medications, no making it simpler. [FG]*

5. Tighten nursing home admission standards

Using Medicare Advantage plans as a model, examine legal and regulatory possibility of increasing controls and clinical criteria for every NH admission and length of stay through a gatekeeper model. When there is a proposed admission, the gatekeeper should make an expeditious determination of what is needed to remain in the community and facilitate those services to avoid the admission. Participants also noted that nurses need to be reimbursed for home visits to determine what HCBS can be set up to keep the person at home.

6. Create multi-payor initiative(s)

Participants reported that Rhode Island Medicaid currently has an ACO model where all providers have "skin in the game" for the total cost of care, but noted that these do not currently extend to duals or to LTSS. They believe many providers would be interested in extending that model to LTSS under certain conditions. For the model to work, entities other than the insurer must take on risk, though some (e.g., home health agencies and NHs) may be reluctant to accept financial risk. They suggested that the state start with one-sided (upside only) payments and gradually move to two-sided risk. To incentive this approach, there should be global payments for total cost of care and broad partnerships that include community health centers. To interest providers, there should be a relaxation of regulations and reporting burdens and flexibility to manage the pool of money and distribute incentives.

I've got EOHHS looking over my shoulder every single day asking 'What did you do today, counted, reported in this way'…If some relaxation of the requirements give(s) us the flexibility to then pass them on to the provider… Without that, the prescriptive nature of what we have to do every day, we have to pass along. [FG]

Some of us, at least where I work, want to do this work because we enjoy doing it…if we at least got our costs covered and there's a chance to earn a little a bit to cover our other expenses, we'd be willing to do it. It's a business, and we've gone into the business to help decrease long-term care use… [The state is] spending too much money on facility use. [FG]

Another category of capitation that should be explored is persons with both behavioral and medical challenges, with a flexible "total cost of care" payment to the network. Some persons with BH issues are not medically complex but remain in NH for safety reasons related to the BH issues.

7. Promote telehealth services

The technology exists, but it needs to be secure, and regulatory relief would be required to provide direct consumer telehealth services. "Specialist to non-specialist" telehealth is already working to some extent, though there are also credentialing and regulatory "medical practice" hurdles that must be addressed for out of state specialists. For consumers, a simple smart phone and data plan could unlock streamlined services and prevent many emergency department visits and unnecessary hospital and NH admissions.

8. Promote or increase nursing home diversion

The discussion on NH diversion during the Delivery System focus group paralleled the feedback received on the topic of Nursing Home Partnerships that resulted in the recommendation above to "Invest in more accessible, affordable housing and community services." Lack of community housing and services not only makes NH discharge more difficult, but also impedes the state's ability to divert consumers who are pre-eligible for Medicaid from facility care to less expensive HCBS. Policy recommendations for enhancing the state's diversion capability entail increasing investments in housing and in the broad range of community HCBS.

I think the broader issue is what can we do policy-wise to delay need for nursing care, and that's making investments in the other programs (i.e. adult day health, home care, Medicaid waiver program). The Medicaid waiver entity we operate, the waiting list is very extensive, when we have turnover there's no problem filling it, there is definitely a need for a significant chunk of the Medicaid population that could go into assisted living waiver units where they're now getting 3 meals a day, staff keeping eye on them 24/7, assistance with medications, managing their care, etc. Programs like this delay the need for nursing home care and save the state money in the long run. But there are not enough Medicaid waiver units to meet the demand. You could look at it through talking to nursing home providers to convert to Medicaid waiver units or assisted living. [KII]

It seems to me that by the time a person needs to apply for Medicaid, a lot of interventions that could have prevented that application at that time and the severity of their need could've been prevented. And it's always struck me that… the missed opportunity to be able to try to do some interventions before a person has to go on Medicaid because then you have your asset limitations and all that stuff. [FG]

9. Expand HCBS workforce and access to geriatric providers

Respondents agreed that currently there are not enough quality home care workers to meet the demand for HCBS – current home care employment practices such as low pay and lack of benefits discourage trained workers from entering the field. Respondents suggested that certified nurse assistants (CNAs) from closed NHs could then become part of the HCBS workforce.

> *Once it's approved, the whole other issue with the home care agencies, there's been a lot of mismatches, a lot are closing, lack of home health aids and CNAs. Luckily in our catchment it hasn't been that difficult, but it's more difficult in rural areas to fill cases. Once we get that approval, it can be difficult to find staff to actually go in there. Another problem can be the care plan – early morning and weekend hours are always tough. [KII]*
>
> *It's all well and good to get them home with the professionals, and once we get the financing in order, but there's not the caregivers. The staffing right now is absolutely a mess in the state. People that have the money can't even find the people to provide the care for them, and that's where we're seeing. We're seeing a major shortage in staffing for homecare both private and under a long-term care servicing situation. [FG]*

To address the lack of primary care providers who practice in geriatrics, respondents suggested Rhode Island target PCPs and other medical professionals for geriatric-sensitive training that includes community-based care options and dementia care. Work with MCOs to provide incentives for the training. The lack of geriatric-specific training, including dementia care, for most physicians, nurses, and other professionals leads to the presumption that all frail, mobility-challenged older adults belong in an institution.

In addition, there are no incentives for PCPs to take ownership of the wider range of services needed by many older adults. Informants cited evidence that only 6 percent of physicians have taken advantage of the Medicare Advance Care Planning benefit, possibly due to lack of knowledge, skill, or confidence.

> *They're pretty much very passive in how to care for older folks. So if older folk[s] call in sick with all these problems, 'send them to the emergency room, send them to an institution'…They're safest at home, but there's this institutional bias that says 'If I put them in a nursing facility they'll be safe.' And it's absolutely the opposite of the truth. [FG]*

Appendix A: Environmental Scan Policy Focus Areas

1. Streamlining the HCBS Eligibility Process
2. Nursing Facility Right-Sizing and Culture Change
3. Improving Identification and Targeting of "Pre-Medicaid"
4. Improving Access to HCBS
5. Nurse Delegation
6. Improving Hospital/Nursing Home Transitions
7. Expanding Home-Based Primary Care
8. Caregiver Supports
9. Alzheimer's/Dementia Program Development

Appendix B: Key Informant Interviews and Focus Groups by Topic

Topic	Number of Key Informant Interviews	Number Invited to Focus Group	Number Attending Focus Group
Eligibility Process	2	9	4
Communication, Awareness, and Access to Information	2	11	6
Nursing Home Partnerships	3	16	7
Delivery System, Provider, and Process Transformation	0	15	6

Appendix C: Rebalancing – Challenges and Key Drivers Inhibiting Systems Transformation

A. Eligibility Process – Barriers Identified

- Lack of timely access to LTSS and other Medicaid benefits: Average turnaround time for processing Medicaid financial eligibility for LTC was 53.55 days in the 2014 – complicated cases can take 6 months or more
- No presumptive eligibility for HCBS LTSS populations in Rhode Island. The state may accept self-attestation of the financial eligibility criteria for new LTC applicants for a maximum of 90 days under the current 1115 Wavier authority (not yet implemented).
- Difficulty obtaining info for LTC application: for elderly clients (e.g. homeless may not have ID cards; hard for many to get bank statements)
- PCP paperwork hard to fill out, subjective, may require a new visit that slows down the process
- Personal needs allowance: too low
- Level of care process and eligibility is unknown – a 'black box'
- Waiting time just to get the functional assessment
- Under 65 year old – complicated, multi-step field to meet SSI disability criteria; fragmented, multi-step Medicaid eligibility process for <65, fragmented eligibility for low income >65
- Missed opportunities for diversion
- 90-day delay to get services
- Not knowing how to use new UIES
- Financial eligibility criteria – not known for HCBS. Need standardized rules, no clarify for services on waivers
- Effect on the provider side – no good system to notify providers of approval and how/when they can bill, so delays in payment

B. Communication, Awareness, and Access to Information – Barriers Identified

- Not having a central source of information
- Lack of information about THE POINT or what number to call
- Lack of website with easily accessible LTSS information for multiple audiences
- Need-to-know timing of information: information is out there, but people don't remember it when they need it

- More information about NHs available than about HCBS: all NH services 24/7 can be described in a pamphlet, but there's no easily understandable package for the 15-20 services that make up HCBS. Persons/families have to coordinate those themselves.
- Most serious gap in information for pre-Medicaid when they need it to stay in the community; at least the Medicaid LTC process makes families think about their options
- Those screened for state services who don't qualify are told "we can't help you" and not given counseling about other options. State leaves people on their own until Medicaid eligible. When they show up at a hospital/NH, it's too late
- Data is limited and lacks comparative information or benchmarks
- Need impartial detailed advice, not just information.
- MCO controls the message – get info from Medicare re NH. How to leverage that method for HCBS information
- Standards of communication response from agencies vary
- Minimal individual awareness of spectrum of services and needs
- Lack of access to Medicaid system for THE POINT
- THE POINT only as accurate as information from state which changes. RI/DHS and THE POINT information gap.
- Limited capacity of THE POINT
- No "No Wrong Door" system where partners are all given the same current and correct information.

C. Nursing Home Partnerships – Barriers Identified

- Bed capacity: NH residents per 1000 residents 65+: At 53, highest in New England and 5th highest in the country
- No incentive for NHs to discharge
- No incentive to reduce occupancy by converting double bed to single rooms
- Geographic differences in occupancy rates (some may be over-bedded)
- Lack of good housing alternatives and community services for persons in NH who want to return to the community. Hard to safely discharge
- Current efforts to modify regulatory structure to support innovative housing models (i.e., supportive care home) – some stakeholders perceive state or federal regulations to be too restrictive
- Stakeholder perspective that state operates top down/behind the scenes without enough conversation
- Endemic institutional bias that few current residents can live in the community
- Concern that reducing bed capacity will lead to decrease in quality of care

- Value of transition vs. diversion efforts (broader issue is investing in community programs to delay NH care)
- Many NHs are 35-50 years old; need structural investment to upgrade to 2016 caregiving model
- CMS Final Rule – Cannot convert part of NH into assisted living or other community housing
- New initiatives may need broad coalition support for change which is difficult to achieve (state, facility providers, federal/CMS, community providers)
- Provider knowledge – PCPs do not know what supports are available in the community
- Clients and caregivers not aware of HCBS options; need for more care usually happens when there is a crisis
- Transition services needed – need PT Evaluation to go home
- Takes longer to obtain eligibility and access to HCBS, so safer for hospital discharge planner to send consumer to NH
- Unified Integrated Eligibility System (UIES) system not working
- Home health care workforce issues – cannot get good workers, no evening/night workers
- NH is cheaper than HCBS for private payors
- Less worry if in NH for caregiver
- NH willing to take presumptive eligibility risk; community services are not
- Issue of care for old old (85+), ambulatory with dementia, low physical needs

D. Delivery System, Provider, and Process Transformation – Key Drivers Inhibiting Rebalancing

- Lack of prevention and caregiver supports; these include:
  - Limited community, medical, and social supports to mitigate impact of emerging challenges faced by the growing aging population
  - Insufficient information/supports to make informed choices prior to and at the point of crisis
  - Insufficient use of home and community-based options to divert use of facility care at hospital discharge, emergency room visit, medical appointment, etc.
  - Substantial caregiver burden
- Financing and delivery system disconnects (across payment/delivery systems and social/medical needs); these include:
  - Financial incentives for hospitals and NHs favor institutionalization
  - Payer responsibilities delimited to shift costs: Medicare –> private pay –> Medicaid

  - Insufficient financial systems to support use of less expensive HCBS by pre-Medicaid population
  - Overreliance on the medical model when social factors play a large role
  - Providers – physicians, psychiatrists, nurses – not prepared to care for geriatric patients
    - Lack of LTSS resources for providers; no incentives to get geriatric training
    - Often just send patients to NH, ER, Hospital
  - Gaps in continuum of supports, transportation, lack of affordable housing, and capacity of HCBS system
    - Housing regulations discourage small, supportive-care housing alternatives
    - HCBS workforce shortage
    - Unmet need for community-based behavioral health services

- Endemic institutional bias; these include:
  - Industry structure – "Over-bedded"
    51 NF beds/1,000 65+ RIers (National average is 36 NF beds/1,000 65+)
  - Cumbersome eligibility process for LTSS
  - Medicaid financial incentives encourage choice of institutional over community care
  - Healthcare workforce bias – Send to NH because more safe there than at home. Presumption that all frail, mobility-challenged individuals belong in a facility
- Limited accountability for outcomes; these include:
  - No one owns service integration or is accountable for overall outcomes, only specific services
  - Current Medicaid systems are weak and do not leverage points of contact such as at hospital discharge for intervention before using Medicaid
  - Systemic lack of interventions to reduce or prevent use of Medicaid by pre-eligibles
  - Need to build partnerships across systems that are currently separate and disconnected

Appendix D: Potential Partners and Barriers by Recommendation

Recommendation	Potential Partners	Potential Barriers
Presumptive financial eligibility	• Dept of Health Services • State and federal Medicaid • LTSS entities • Hospitals • Managed care organizations	• Regulations on assessor qualifications • Reimbursement rate to private assessors
Expedited eligibility	• Dept of Health Services • LTSS entities • Hospitals • Managed care organizations	• Regulations on assessor qualifications • Reimbursement rate to private assessors
True single waiver system	• Dept of Health Services • Division of Elderly Affairs • HCBS waiver administrators • State and federal Medicaid • Office of Medical Review • Consumers and advocates	• Buy-in from waiver and HCBS program managers • Buy-in from advocates and consumers
Use standardized assessment tool and assessment process	• Dept of Health Services • Division of Elderly Affairs • HCBS waiver administrators • Office of Medical Review • Consumers and advocates	• Funds to develop or adopt standardized tool • Buy-in from waiver and HCBS program managers • Buy-in from advocates and consumers
Fully electronic Medicaid and HCBS eligibility platform	• Dept of Health Services • Division of Elderly Affairs • HCBS waiver administrators • State and federal Medicaid • State Division of Technology • SSDI Medical review team	• Time, personnel, and funds for development and maintenance
Streamline exchange of financial and functional information	• Dept of Health Services • Division of Elderly Affairs • HCBS waiver administrators • State Division of Technology • Office of Medical Review	• Time, personnel, and funds for development and maintenance • Agreement among state unit partners
Leverage THE POINT	• Division of Elderly Affairs • United Way	• Funds for additional staff and other resources • Increased demand may not be met in short run • Possible duplication of electronic systems already in place
Community awareness campaign	• Community organizations	• Increased cost to state for HCBS in short run; NH savings only in long run

Recommendation	Potential Partners	Potential Barriers
Reduce NH bed capacity	• NH industry • Leading Age RI & RI Health Care Assn • Hospitals and discharge planners • Managed care organizations • Home health providers • Workers' unions • Workforce Investment Board • Department of Labor	• Current system/culture: discharges to NHs encouraged; easier for MCO consumer to get NH bed; harder to use Medicare for equipment/HCBS • Approx 200 mothballed beds may need to be bought out first • Workforce issues; lack of sufficient HCBS staff to meet demand; high turnover & low pay; CNAs lose pay and benefits moving to home care • Lack of MH and BH services in the community • Cost of buyouts and higher rates for single rooms vs. subsequent savings
Expand NH business models	• NH industry • CMS • RI Medicaid	• CMS HCBS Settings Rule • Age of buildings may require substantial costs of renovation
Invest in community housing and services	• Community HCBS providers • Housing Resources Commission • RI Housing • Housing developers • SASH, Beacon Hill Village	• Funding • Regulatory burdens • Lack of skilled community workforce • Supportive housing regulations
Increase use of PACE	• PACE • Hospitals • Acute care providers • NH social workers • THE POINT	• Misconception that PACE is Medicaid
Expand HCBS workforce	• Workers' unions • Workforce Investment Board • Department of Labor	• Funding for training and pay • Labor laws • CNAs trained in RI go to other states for better pay